Title 15: Mississippi Department of Health
Part 12: Bureau of Emergency Medical Services
Subpart 31: Emergency Medical Services

Chapter 2 TRANSFERS

Subchapter 1 General Information

Rule 2.1.1 EMS personnel are restricted to performance of those skills as authorized by the State Department of Health, Bureau of Emergency Medical Services. EMS personnel cannot transport patients with needs or reasonably perceived needs for care which exceed the scope of practice for the ambulance attendant.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.2 The only exception to the above is as follows:

1. EMT's may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

2. There is no need, or reasonably perceived need, for the device or procedure during transport; and

3. An individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.3 Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.4 Ambulance personnel aiding in the transfer should confirm that the facility to which the patient is to be transferred has been notified and has agreed to accept the patient. They should also inquire whether the patient's condition is stable (no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from the facility) and whether a nurse, physician or other medical personnel should accompany the patient during transfer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.5 If a patient at a hospital has an emergency medical condition which has not been stabilized (as defined herein), the hospital should not request the transfer and the ambulance service should not transfer the patient unless:

1. the patient (or legally responsible person acting on the patient's behalf) request that the transfer be effected;

2. a physician or other qualified medical personnel when a physician is not readily available, has verified that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer; or,

3. the transfer is an appropriate transfer to that facility.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 INTERFACILITY PATIENT TRANSFERS

Rule 2.2.1 Medical direction is a critical component of all ground and air ambulance services, including interfacility transfer services. Air and ground ambulances that transfer patients must be capable of providing emergency care during transport. Optimal planning for transfer considers individual patient medical requirements and an understanding of the capabilities of the personnel and system used for patient transfer. The system design, determination of the scope of practice of its providers, and the assurance that patient care is rendered consistent with this scope of practice, are essential medical direction functions.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.2.2 Medical direction of the transferred patient is a shared responsibility. The transferring physician is responsible under Federal laws for assuring that the patient is transferred by qualified personnel and appropriate equipment. The designation of on-line medical control for the interfacility transfer of patients is the responsibility of the EMS system and its off-line medical director.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Definitions - Inter-Hospital And Other Medical Facilities

Rule 2.3.1 Appropriate Transfer - An appropriate transfer to a medical facility is

1. A transfer in which the receiving facility: a) has available space and qualified personnel for the treatment of the patient, and b) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

2. In which the transferring hospital provides the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital;

3. In which the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.3.2 Medical Control During Interhospital Transfers

1. Once an emergency patient arrives for initial evaluation at a medical facility the patient becomes the responsibility of that facility, and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by personnel and a facility of equal or greater capability for the patient's existing condition.

2. Should questions or problems arise during transfer, or in event of an emergency, one of the following (whichever is most appropriate based on service's approved Medical Control Plan) shall be contacted for medical guidance, as outlined in BEMS approved medical control plan: Online Medical Direction; Transferring Physician; or Receiving Physician.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Interhospital Transfers

Rule 2.4.1 If a transfer is being made for the convenience of the patient or patient's physicians, and the patient is not receiving treatment, and is expecting to remain stable during transport, the transfer may be conducted by and appropriately trained medical provider (EMT-Basic or higher).

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.2 Routinely, the transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility. Care initiated by the transferring facility may need to be continued during transport. The transferring physician will determine the treatment to be provided during the period of the patient transport, and what, if any, staff will be necessary to accompany the patient en-route.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.3 Should questions or problems arise during transfer, or in event of an emergency, one of the following (whichever is most appropriate based on service's approved Medical Control Plan) shall be contacted for medical guidance: Online Medical Direction; Transferring Physician; or Receiving Physician.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.4 Documentation must include the interventions performed en-route and by whom the intervention was performed, and condition of patient upon transfer to the receiving facility.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 4 Medical First Responder

Subchapter 11 Grounds for Suspension or Revocation

Rule 4.11.1 Grounds for Suspension or Revocation include:

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty.

6. Recklessly disregarding the speed regulations prescribed by law while on duty.

7. Failure to maintain current registration by the National Registry of EMTs.

8. Failure to maintain all current training standards as required by the State Department of Health.

9. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

10. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

11. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the State Department of Health, BEMS, pertaining to pre-hospital personnel.

12. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

13. Unauthorized, misuse or excessive use of narcotics, dangerous drugs, or controlled substances or alcoholic beverages.

14. Functioning outside the Medical First Responder scope of practice.

15. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

16. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

17. Failure to comply with an employer's request for drug and alcohol testing.

18. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-81

Chapter 6 EMERGENCY MEDIAL TECHNICIAN BASIC (EMT-B)

Subchapter 14 EMT, Grounds for Suspension or Revocation

Rule 6.14.1 Grounds for Suspension or Revocation include:

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty

6. Disregarding the speed regulations prescribed by law while on duty.

7. Failure to maintain current registration by the National Registry of EMTs.

8. Failure to maintain all current EMT training standards as required by the BEMS.

9. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

10. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

11. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

12. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

13. Unauthorized, misuse or excessive use of, narcotics, dangerous drugs, or controlled substances or alcoholic beverages.

14. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the BLS provider.

15. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

16. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

17. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

18. Failure to comply with an employer's request for drug and alcohol testing.

19. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 19 Performance Standards for EMT.

Rule 6.19.2 Skills included in the Scope of Practice for a Mississippi EMT includes the following:

1. Oropharengeal and Nasopharengeal Airway

2. Bag-Valve Mask

3. Sellick's Maneuver

4. Demand Valve – manually triggered ventilation

5. Head Tilt Chin Lift

6. Jaw Thrust

7. Modified Jaw Thrust

8. Mouth to Barrier; Mouth to Mask; Mouth to Mouth; Mouth to Nose; Mouth to Stoma

9. Obstruction – Manual

10. Oxygen Therapy – humidifiers; Oxygen Therapy –Nasal Cannula; Oxygen Therapy –Non-rebreather mask; Oxygen Therapy –Partial rebreathr mask; Oxygen Therapy –simple face mask; Oxygen Therapy –Venturi mask

11. Pulse oximetry

12. Suctioning – Upper airway;

13. Ventilator – Automated transport (ATV) *(prehospital, nonintubated patient)* - (beginning April 1, 2014);

14. Cardiopulmonary Resuscitation (CPR)

15. Defibrillation – automated/semi-automated

16. Hemorrhage control – Direct pressure; Hemorrhage control – tourniquet

17. MAST/PASG

18. Mechanical CPR Device (beginning April 1, 2014);

19. Spinal immobilization – cervical collar; Spinal immobilization – long board; Spinal immobilization – manual; Spinal immobilization – seated patient; Spinal immobilization – rapid manual extrication;

20. Extremity stabilization – manual;

21. Extremity splinting; Splint – traction

22. Mechanical patient restraint;

23. Emergency moves for endangered patients;

24. Assisting patient with his/her own prescribed medications (aerosolized/nebulized); Oral Glucose; Oral Aspirin; sublingual nitroglycerine; Auto-injector (self or peer care); Auto-injector (patient's own prescribed medication;

25. Assisted delivery (childbirth); Assisted complicated delivery (childbirth)

26. Blood pressure – automated (beginning April 1, 2014); Blood pressure – manual;

27. Eye irrigation

SOURCE: Miss. Code Ann. §41-59-5

Chapter 7 EMERGENCY MEDICAL TECHNICIAN ADVANCED LEVEL SUPPORT

Subchapter 18 EMT Intermediate, Grounds for Suspension or Revocation.

Rule 7.18.1 Grounds for Suspension or Revocation include:

1. The BEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

2. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

7. Disregarding the speed regulations prescribed by law while on duty.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current EMT-Advanced training standards as required by the BEMS.

10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Unauthorized, misuse or excessive use of, narcotics, dangerous drugs, or controlled substances or alcoholic beverages.

15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

16. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

18. Failure to comply with the requirements of a Mississippi EMS scholarship program.

19. Failure to comply with an employer's request for drug and alcohol testing.

20. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 19 Paramedic, Grounds for Suspension or Revocation.

Rule 7.19.1 Grounds for Suspension or Revocation include:

1. The BEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

2. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

7. Disregarding the speed regulations prescribed by law while on duty.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current EMT-Advanced training standards as required by the BEMS.

10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Unauthorized, misuse or excessive use of, narcotics, dangerous drugs, or controlled substances or alcoholic beverages.

15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

16. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

18. Failure to comply with the requirements of a Mississippi EMS scholarship program.

19. Failure to comply with an employer's request for drug and alcohol testing.

20. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Chapter 3 AERO MEDICAL SERVICES

Subchapter 5 Off-Line Medical Direction

Rule 3.5.1 Qualifications: Each air ambulance service shall designate or employ an off-line medical director. The off-line medical director shall meet the following qualifications:

1. The off-line medical director shall be a physician (MD or DO) currently licensed and in practice.

2. The physician shall be licensed to practice medicine in the state(s) where the service is domiciled.

3. Services having multiple bases of operation shall have an off-line medical director for each base. If the off-line medical director for the service's primary location is licensed in the state where the base(s) is/are located, they may function as the off-line medical director for that base in place of a separate individual.

4. Must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

5. The off-line medical director shall have knowledge and experience consistent with the transport of patient's by air.

6. Beginning January 2013, all Mississippi Off-Line Medical Directors shall take Medical Director’s course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

Rule 3.5.3 On-line Medical Control:

1. The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and

resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

2. All Mississippi On-Line Medical Directors are recommended and encouraged to take Medical Director's course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

APPENDIX I – MEDICAL DIRECTION: STANDARD PRACTICE FOR QUALIFICATIONS, RESPONSIBILITIES, AND AUTHORITY

Medical Direction (pre-hospital Emergency Medical Services)

All aspects of the organization and provision of emergency medical services (EMS), including both basic and advanced life support, require the active involvement and participation of physicians. These aspects should incorporate design of the EMS system prior to its implementation; continual revisions of the system; and operation of the system from initial access, to pre-hospital contact with the patient, through stabilization in the emergency department. All pre-hospital medical care may be considered to have been provided by one or more agents of the physician who controls the pre-hospital system, for this physician has assumed responsibility for such care.

Implementation of this standard practice will insure that the EMS system has the authority, commensurate with the responsibility, to insure adequate medical direction of all pre-hospital providers, as well as personnel and facilities that meet minimum criteria to implement medical direction of pre-hospital services.

OFF-LINE (PROSPECTIVE AND RETROSPECTIVE) MEDICAL DIRECTION

Off-line medical direction includes the administrative promulgation and enforcement of accepted standards for out-of-hospital care. Off-line medical direction can be accomplished through both prospective and retrospective methods. Prospective methods include, but are not limited to, training, testing and credentialing of providers, protocol development, operational policy and procedures development, and legislative activities. Off-line medical direction shall ensure the qualifications of out-of-hospital personnel involved in patient care and dispatch are maintained on an ongoing basis through education, testing, and credentialing as the local/state authorities have determined. Retrospective activities include, but are not limited to medical audit and review of care, (process improvement), direction of remedial education, and limitation of patient care functions if needed. Committees functioning under the medical director with representation from appropriate medical and provider personnel can perform various aspects of prospective and retrospective medical direction.

Each EMS agency providing pre-hospital care shall be licensed by the Mississippi State Department of Health, BEMS, and shall have an identifiable off-line Medical Director who after consultation with others involved and interested in the agency is responsible for the development, implementation and evaluation of standards for provision for medical care within the agency.

All pre-hospital providers (including EMT-Bs) shall be medically accountable for their actions and are responsible to the off-line Medical Director of the licensed EMS agency that approves their continued participation. All pre-hospital providers, with levels of certification EMT-B or above, shall be responsible to an identifiable physician who directs their medical care activity. The off-line Medical Director shall be appointed by, and accountable to, the appropriate licensed EMS agency.

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to EMS personnel on board any permitted unit at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

Requirements of a Medical Director

To optimize off-line medical direction of all out-of-hospital emergency medical services, these services should be managed by physicians who have demonstrated the following:

1. Mississippi licensed physician, M.D. or D.O.
2. Familiarity with the design and operation of out-of-hospital EMS systems.
3. Experience or training in the out-of-hospital emergency care of the acutely ill or injured patient.
4. Experience or training in medical direction of out-of-hospital emergency units.
5. Active participation or reasonable associated experience in the ED management of the acutely ill or injured patient.
6. Experience or training in the instruction of out-of-hospital personnel.
7. Active involvement in the training of pre-hospital personnel.
8. Experience or training in the EMS performance improvement process.
9. Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.
10. Knowledge of EMS laws and regulations.
11. Knowledge of EMS dispatch and communications.
12. Knowledge of local mass casualty and disaster plans including preparation for responding to terrorism and weapons of mass destruction.

13. By July 1, 2017, board certification in emergency medicine by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.

14. Completion of an EMS Medical Directors training course. (Effective January, 2013)

15. Familiarity with base station operations where applicable, including communication with, and direction of, pre-hospital emergency units.

16. Knowledgeable of the administrative and legislative process affecting the local, regional and/or state pre-hospital EMS system.

17. Knowledgeable of laws and regulations affecting local, regional and state EMS.

18. Approved by the State EMS Medical Director

Responsibilities of an off-line Medical Director includes, but is not limited to:

To optimize off-line medical direction of all out-of-hospital emergency medical services, physicians functioning as medical directors should, at a minimum:

1. Serve as patient advocates in the EMS system.

2. Set and ensure compliance with patient care standards including communications standards and dispatch and medical protocols.

3. Develop and implement the protocols and standing orders under which the out-of-hospital care provider functions.

4. Develop and implement the process for the provision of concurrent medical direction.

5. Ensure the appropriateness of initial qualifications of out-of-hospital personnel involved in patient care and dispatch.

6. Ensure the qualifications of out-of-hospital personnel involved in patient care and dispatch are maintained on an ongoing basis through education, testing, and credentialling as the local/state authorities have determined.

7. Develop and implement an effective process improvement program for continuous system and patient care improvement.

8. Promote EMS research.

9. Maintain liaison with the medical community including, but not limited to, hospitals, emergency departments, physicians, out-of-hospital providers, and nurses.

10. Interact with regional, state, and local EMS authorities to ensure that standards, needs, and requirements are met and resource utilization is optimized.

11. Arrange for coordination of activities such as mutual aid, disaster planning and management, and hazardous materials response including weapons of mass destruction and terrorism. This must include training of providers in these areas.

12. Promulgate public education and information on the prevention of emergencies.

13. Maintain knowledge levels appropriate for an EMS medical director through continued education.

Authority of an off-line Medical Director includes, but is not limited to:

Unless otherwise defined or limited by state or regional requirements, the medical director shall have authority over all clinical and patient care aspects of the EMS system including, but not limited to, the following:

1. Recommend certification, recertification, and decertification of non-physician out-of-hospital personnel to the appropriate certifying agency.
2. Establish, implement, revise, and authorize the use of system-wide protocols, policies, and procedures for all patient care activities from dispatch through triage, treatment, transport, and/or non-transport.
3. Establish criteria for determining patient destination in a non-discriminatory manner in compliance with state guidelines as appropriate.
4. Ensure the competency of personnel who provide on-line medical direction to out-of-hospital personnel including, but not limited to, physicians, EMTs, Paramedics and nurses.
5. Establish the procedures or protocols under which non-transport of patients may occur.
6. Require education and testing to the level of proficiency approved for the following personnel within the EMS system:
    a. EMTs
    b. Paramedics
    c. Nurses involved in out-of-hospital care
    d. Dispatchers
    e. Educational coordinators
    f. On-line physicians
    g. Off-line physicians

7. Implement and supervise an effective process improvement program. The medical director shall have access to all relevant records needed to accomplish this task.
8. Remove a provider from medical care duties for due cause, using an appropriate review and appeals mechanism.
9. Set or approve hiring standards for personnel involved in patient care.
10. Set or approve standards for equipment used in patient care.
11. Establishing system-wide medical and trauma protocols in consultation with appropriate specialists.
12. Establishment of system-wide trauma protocols as delineated for Statewide systems of care.
13. Recommending certification or decertification of non-physician pre-hospital personnel to the appropriate certifying agencies. Every licensed agency shall have an appropriate review and appeals mechanism, when decertification is recommended, to assure due process in accordance with law and established local policies. The Director shall promptly refer the case to the appeals mechanism for review, if requested.
14. Requiring education to the level of approved proficiency for personnel within the EMS system. This includes all pre-hospital personnel, EMTs at all levels, pre-hospital emergency care nurses, dispatchers, educational coordinators, and physician providers of on-line direction.
15. Suspending a provider from medical care duties for due cause pending review and evaluation. Because the pre-hospital provider operates under the license (delegated practice) or direction of the Medical Director, the Director shall have ultimate authority to allow the pre-hospital provider to provide medical care within the pre-hospital phase of the EMS system.
16. Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) is dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.
17. Establishing under which circumstances a patient may be transported against his will; in accordance with, state law including, procedures, appropriate forms and review process.
18. Establishing criteria for level of care and type of transportation to be used in pre-hospital emergency care (i.e., advanced life support vs. basic life support, ground air, or specialty unit transportation).
19. Establishing criteria for selection of patient destination.
20. Establishing educational and performance standards for communication resource personnel.
21. Establishing operational standards for communication resource.
22. Conducting effective system audit and quality assurance. The Medical Director shall have access to all relevant EMS records needed to accomplish this task. These documents shall be considered quality assurance documents and shall be privileged and confidential information.
23. Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.
24. May delegate portions of his/her duties to other qualified individuals.

25. The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.
26. Medical direction with concurrent and retrospective oversight supervision;
27. Standardized protocols;
28. Actively engaged in a continuous quality assurance, quality control, performance review, and when necessary, supplemental training.

Medical Direction (Online, Direct Medical Control)

On-line medical direction is the medical direction provided directly to out-of-hospital providers by the medical director or designee, as defined in the BEMS approved medical control plan, generally in an emergency situation, either on-scene or by direct voice communication. The mechanism for this contact may be radio, telephone or other means as technology develops, but must include person-to-person communication of patient status, and orders to be carried out. Ultimate authority and responsibility for concurrent medical direction rests with the off-line medical director.

The practice of on-line medical direction shall exist and be available within the EMS system, unless impossible due to distance or geographic considerations. All credentialed pre-hospital providers-shall be assigned to a specific on-line communication resource by a predetermined policy and this shall be included in the application for ALS licensure.

When EMS personnel are transporting patients to locations outside of their geographic medical control area, they may utilize recognized communication resources outside of their own area.

Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.

On-line medical direction is the practice of medicine and all orders to which the pre-hospital provider shall originate from/or be under the direct supervision and responsibility of a physician.

The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.

Requirements of a Medical Director

1. This physician shall be approved to serve in this capacity by system (Off-Line) Medical Director.

2. This physician shall have received education to the level of proficiency approved by the off-line Medical Director for proper provision of on-line medical direction, including communications equipment, operation and techniques. (January 2013)

All Mississippi On-Line Medical Directors are encouraged to complete the Medical Director's course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

3. This physician shall be appropriately trained in pre-hospital protocols, familiar with the capabilities of the pre-hospital providers, as well as local EMS operational policies and regional critical care referral protocols.

4. This physician shall have demonstrated knowledge and expertise in the pre-hospital care of critically ill and injured patients.

5. This physician assumes responsibility for appropriate actions of the pre-hospital provider to the extent that the on-line physician is involved in patient care direction.

6. The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

7. The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

8. There must be – at all times - Medical direction with concurrent and retrospective oversight supervision; Standard Protocols; Continuing quality assurance, quality control, performance review, and when necessary, supplemental training.

Authority for Control of Medical Services at the Scene of Medical Emergency.

Authority for patient management in a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.

The pre-hospital provider is responsible for the management of the patient and acts as the agent of medical direction.

Authority for Scene Management.

Authority for the management of the scene of a medical emergency shall be vested in appropriate public safety agencies. The scene of a medical emergency shall be managed in a manner

designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious risks to life and health. Public safety personnel shall ordinarily consult emergency medical services personnel or other authoritative medical professionals at the scene in the determination of relevant risks.

Patient's Private Physician Present

The EMT should defer to the orders of the private physician. The base station should be contacted for record keeping purposes if on-line medical direction exists. The ALS squad's responsibility reverts back to medical direction or on-line medical direction at any time when the physician is no longer in attendance.

Intervener Physician Present and Non-Existent On-Line Medical Direction

When the intervener physician has satisfactorily identified himself as a licensed physician and has expressed his willingness to assume responsibility and document his intervention in a manner acceptable to the local emergency medical services system (EMSS); the pre-hospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocol.

If treatment by the intervener physicians at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital. In the event of a mass casualty incident or disaster, patient needs may require the intervener physician to remain at the scene.

Intervener Physician Present and Existent On-Line Medical Direction

If an intervener physician is present and on-line medical direction does exist the on-line physician should be contacted and the on-line physician is ultimately responsible.

The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him to assume responsibility.

If there is any disagreement between the intervener physician and the on-line physician, the pre-hospital provider should take orders from the on-line physician and place the intervener physician in contact with on-line physician.

In the event the intervener physician assumes responsibility, all orders to the pre-hospital provider shall be repeated to the communication resource for purposes of record-keeping.

The intervener physician should document his intervention in a manner acceptable to the local EMS system.

The decision of the intervener physician to accompany the patient to the hospital should be make in consultation with the on-line physician. Nothing in this section implies that the pre-hospital provider CAN be required to deviate from system protocols.

Communication Resource

A communication resource is an entity responsible for implementation of direct (on-line) medical control. This entity/facility shall be designated to participate in the EMS system according to a plan developed by the licensed ALS provider and approved by the system (off-line) medical director and the State Department of Health, BEMS.

The communication resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system medical director.

The communication resource shall assure that all requests for medical guidance assistance or advice by pre-hospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility and cooperation.

The communication resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the pre-hospital care program as long as patient confidentiality is not violated.

1. The communication resource will consider the pre-hospital provider to be the agent of the on-line physician when they are in communication, regardless of any other employee/employer relationship.

2. The communication resource shall assure that the on-line physicians will issue transportation instructions and hospital assignments based on system protocols and objective analysis of patient's needs and facility capability and proximity.

3. No effort will be made to obtain institutional or commercial advantages through use of such transportation instructions and hospital assignments.

4. When the communication resource is acting as an agent for another hospital, the information regarding patient treatment and expected time of arrival will be relayed to the receiving hospital in an accurate and timely fashion.

5. Communication resource shall participate in regular case conferences involving the on-line physicians and pre-hospital personnel for purposes of problem identification and provide continuing education to correct any identified problems.

6. If the communication resource is located within a hospital facility, the hospital shall meet the requirements listed herein and the equipment used for on-line medical direction shall be located within the emergency department.

Educational Responsibilities

Because the on-line and off-line medical directors allow the use of their medical licenses, specific educational requirements should be established. This is not only to insure the best available care, but also to minimize liability. All personnel brought into the system must meet

minimum criteria established by state law for each level; however, the law should in no way preclude a medical director from enforcing standards beyond this minimum.

Personnel may come to the system untrained (in which case the medical director will design and implement the educational program directly or through the use of ancillary instructors), or they may have previous training and/or experience. Although the Department of Transportation has defined curricula for training, the curricula are not standardized nationally, and often are not standardized within a state or county. Certification or licensure in one locale does not automatically empower an individual to function as an EMT within another system. The medical director must evaluate applicants trained outside the system in order to determine their level of competence. Such evaluation may be made in the form of written examinations, but should also include practical skills and a field internship with competent peers and time spent with the medical director.

The educational responsibilities of the medical director do not end with initial training; skills maintenance must be considered. To insure the knowledge does not stagnate, programs should cover all aspects of the initial training curriculum on a cyclical basis. Continuing education should comprise multiple formats, including lectures, discussions and case presentations, as well as practical situations that allow the EMT to be evaluated in action. The continuing education curriculum should also include topics suggested by audits, and should be utilized to introduce new equipment or skills.

Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

Review and Audit

Personnel may be trained to the highest standards and many protocols may be written, but if critical review is not performed, the level of patient care will deteriorate. Review is intended to determine inadequacies of the training program and inconsistencies in the protocols. The data base required includes pre-hospital care data, emergency department and inpatient (summary) data, and autopsy findings as appropriate. The cooperation of system administrators, hospital administrators, and local or state medical societies must be elicited. On occasion, the state legislature may be required to provide access to vital information.

The medical director or a designated person should audit pre-hospital run records, either randomly or inclusively. The data must be specifically evaluated for accuracy of charting and assessment; appropriateness of treatment; patterns of error, morbidity, and mortality; and need for protocol revision.

It cannot be assumed that all pre-hospital care will be supervised by on-line physicians. When proper or improper care is revealed by the audit process, prompt and appropriate praise or censorship should be provided by the medical director after consultation with the system administrator.

Individual Case Review.

Compliance with system rules and regulations is most commonly addressed by state and regional EMS offices. Audit by individual case review requires a more detailed plan. Each of the components defined in detail by the individual EMS system must be agreed on prior to the institution of any case review procedures. Case review may involve medical audit, including reviews of morbidity and mortality data (outcome-oriented review), and system audit, including compliance with rules and regulations as well as adherence to protocols and standing orders (process-oriented review). The personnel to be involved in a given case review process should include the off-line medical director; emergency department and critical care nurses; and EMS, technical and other support personnel who were involved in the specific cases.

The following must be written and agreed to in advance:

Procedural guidelines of how the individuals will interact during meetings.

Because considerations of medical malpractice may be present when issues concerning appropriateness of care and compliance with guidelines are raised, legal advice for procedural guidelines must be obtained prior to the institution of any medical audit program in order that medical malpractice litigation will neither result from nor become the subject of the meeting.

Confidentiality of case review in terms of local open meeting laws and public access to medical records and their distribution.

Format for recording the meeting and its outcome.

Access to overall system performance records, both current and historical, to allow comparison.

Overall outcome data (morbidity and mortality) and individual, unit-specific, and system-wide performance can be measured by the following means:

The severity of presentation of patients must be known, and a scale for that measurement must be agreed on, included in all EMT education, and periodically checked for reliability.

Appropriate treatment on scene and in transit should be recorded and subsequently evaluated for its effect on overall patient outcome.

At the emergency department, the severity of cases presenting (according to a severity scoring technique) and treatment needed should be recorded in detail.

An emergency department diagnosis and outcome in terms of admission to a general medical bed, critical care unit, or morgue must be known. The length of stay in the hospital, cost of stay, discharge status, and pathologic diagnosis should be made available.